STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365886	a. building _____ b. wing _____	**02/13/2019**

name of provider or supplier	street address, city, state, zip code
TOLEDO HEALTHCARE	**2051 COLLINGWOOD BLVD TOLEDO OH, 43620**

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F 0000	INITIAL COMMENTS ANNUAL SURVEY EXTENDED SURVEY ADMINISTRATOR: Katie Gulgin, #6395 CERTIFIED BED CAPACITY: 110 CENSUS: 88 MEDICARE: 0 MEDICAID: 78 OTHER: 10 The following deficiencies are based on the extended survey completed 02/13/19.	F 0000		

laboratory director's or provider/supplier representative's signature | title | (x6) date

CHARLES.NINES | 03/14/2019

any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. for nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. if deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0584	Continued From page 1	F 0584		
F 0584 SS=E	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 0584	In accordance with regulations Toledo Healthcare will ensure that it maintains a safe, clean, comfortable, and homelike environment. Resident's #2, #3, #5, #7, #9, #11, #15, #16, #18, #24, #25, #27, #28, #31, #33, #36, #38, #43, #46, #52, #53, #54, #55, #62, #64, #65, #68, #69, #72, and #79 were assessed on 2/27/19 by the Director of Nursing/designee for adverse reactions related to the deficient practice and none were observed. All like residents were assessed for adverse reactions on 2/27/19 by the Director of Nursing/designee related to the deficient practice and none were observed. In Resident #55 and #79's room, the window shades were replaced, the wall holes by the bed were patched, the dresser toe kick was replaced, the bathroom wall was scraped and patched, and the urine odor was eliminated. In Resident #16 and #54's room, the privacy curtain was replaced. In Resident #52 and #69's room, the bathroom wall was scraped and patched. In Resident #47's room, the toilet paper holder, soap dispenser, and mirror were removed from the bathroom due to resident behaviors. All subsequent holes were patched. The window blinds were replaced, and the dresser drawer was repaired. In Central Shower Room #1, the tiles were replaced and re grouted. In Resident #18 and #72's room, the privacy curtain was replaced, and the bathroom tiles were replaced and re grouted. A building wide audit was completed on 2/28/19 to identify any areas of concern in	03/21/2019

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F 0584	Continued From page 2 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain an intact, sanitary environment for 30 residents (#2, #3, #5, #7, #9, #11, #15, #16, #18, #24, #25, #27, #28, #31, #33, #36, #38, #43, #46, #52, #53, #54, #55, #62, #64, #65, #68, #69, #72, and #79) residing on the fourth floor secured unit. The facility census was 87. Findings include: Observation on 02/12/19 at 4:34 P.M. of Resident #55 and Resident #79's room revealed the window shade had broken edges, there were holes in wall at the head and the foot of the bed, and the toe kick was missing on the bottom of the dresser. The bathroom had peeling plaster present behind the toilet and a strong odor of urine was noted. Interview at the time of the observations on 02/12/19 at 4:34 P.M. with Director of Maintenance (DOM) #500	F 0584	resident living quarters. Administrator educated staff and maintenance director on new maintenance work order request by 3/21/19. Maintenance director will complete monthly inspections for preventative maintenance needs, track, and complete repairs as needed starting the month of March 2019. Administrator will audit work orders and preventative maintenance needs weekly for 4 weeks, monthly for 3 months, and quarterly ongoing starting 3/4/19. Resident environmental conditions will be reviewed quarterly at QAPI.	

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F 0584	Continued From page 3 verified the above findings. Observation on 02/12/19 at 4:35 P.M. of Resident #16 and Resident #54's room revealed the privacy curtain had a large of brown stains present. Interview at the time of the observations on 02/12/19 at 4:35 P.M., DOM #500 verified the above finding. Observation on 02/12/19 at 4:37 P.M. of the bathroom in Resident #52 and Resident #69's room revealed the wall behind the toilet was peeling down to the dry wall. Interview at the time of the observations on 02/12/19 at 4:37 P.M., DOM #500 verified the above finding. Observation on 02/12/19 at 4:37 P.M. of Resident #47's bathroom revealed the toilet paper holder was broken and hanging from the wall. The mirror above the sink was missing, leaving a rough layer of glue where the mirror had been. The soap dispenser was broken and falling off the wall. In the resident's room the bottom drawer to the dresser was broken and the window blind was broken with rough edges exposed. Interview at the time of the observations on 02/12/19 at 4:37 P.M., DOM #500 verified the above findings. Observation on 02/12/19 at 4:38 P.M. of the Central Shower Room #1 revealed three missing tiles on ledge to the shower, exposing rough edges. The shower tile also had a lack grout in some areas.	F 0584		

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F 0584	Continued From page 4 Interview at the time of the observations on 02/12/19 at 4:38 P.M., DOM #500 verified the above findings. Observation on 02/12/19 at 4:40 P.M. of Resident #18 and Resident #72 revealed the privacy curtain by the first bed was torn for approximately 12 inches from the hooks connecting to the tract. There were two missing tiles on the ledge of the shower in the bathroom exposing a rough surface and black substance noted in the gout of the shower tile. Interview at the time of the observations on on 02/12/19 at 4:40 P.M. DOM #500 verified the above findings. The facility identified 30 residents (#2, #3, #5, #7, #9, #11, #15, #16, #18, #24, #25, #27, #28, #31, #33, #36, #38, #43, #46, #52, #53, #54, #55, #62, #64, #65, #68, #69, #72, and #79) residing on the fourth floor secured unit with access to Central Shower Room #1. .	F 0584		

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F 0607	Continued From page 5	F 0607		
F 0607 SS=F	483.12(b)(1)-(3) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This STANDARD is not met as evidenced by: Based on review of employee records, staff interviews, review of a new hire checklist, review of personnel file check list, and review of facility policies, the facility failed to follow their policies to obtain and submit employee fingerprints to the Bureau of Criminal Identification and Investigation (BCI & I). The facility identified 24 employees (Dietary Staff #110, Licensed Practical Nurse (LPN) #111, State Tested Nurse Aide (STNA) #117, Medical Records Staff (MRS) #115, Activity Staff #118, LPN #124, LPN #129, STNA #133, LPN #115, Admissions Staff #135, Registered Nurse (RN) #137, STNA #117, Director of Maintenance (DOM) #500, Social Worker (SW) #400, Dietary Director (DD)#143,	F 0607	Staff were educated on the abuse policy by 3/21/19 by the Director of Nursing. BCI/Fingerprinting was completed on 2/22/19 for all identified employees. Administrator audited employee files to ensure BCI/Fingerprinting was done on all employees 2/25/19. The HR director was educated on 2/24/19 by the Administrator regarding the need to obtain fingerprints with BCI checks. Administrator educated department heads on BCI/Fingerprinting policy and procedure and accurate BCI tracking on 2/24/19 to ensure all new employees are fingerprinted upon hire. Administrator will audit BCI/Fingerprinting completion and log every two weeks for 3 months, monthly for 3 months, and quarterly ongoing starting 3/4/19. BCI/Fingerprinting compliance will be reviewed quarterly at QAPI.	03/21/2019

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F 0607	Continued From page 6 Housekeeper #146, RN #310, Assistant Administrator (AA) #159, Receptionist #166, STNA #116, STNA #171, STNA #175, LPN #178 and STNA #118) who had not had their fingerprints submitted to the BCI & I. This had the potential to affect all 87 residents residing in the facility. Finding include: Review personnel file for STNA #115 revealed a hire date of 12/03/18. There was no evidence a BCI & I fingerprint background checks had been completed. Review personnel file for STNA #116 revealed a date of hire of 11/19/18. There was no evidence a BCI & I fingerprint background checks had been completed. Review personnel file for STNA #117 revealed a date of hire of 08/21/18. There was no evidence a BCI & I fingerprint background checks had been completed. Review personnel file for STNA #118 revealed a date of hire of 07/20/18. There was no evidence a BCI & I fingerprint background checks had been completed. Review personnel file for RN #310 revealed a date of hire of 06/25/18. There was no evidence a BCI & I fingerprint background checks had been completed. Review personnel file for AA #159 revealed	F 0607		

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F 0607	Continued From page 7 a date of hire of 01/18/19. There was no evidence a BCI & I fingerprint background checks had been completed. Interview on 02/13/19 at 7:29 A.M. with AA #159 revealed he had not completed a BCI fingerprint background check since starting employment at the facility on 01/18/19. AA #159 revealed he was aware BCI & I fingerprint checks were required. Review personnel file for DOM #500 revealed a date of hire of 11/26/18. There was no evidence a BCI & I fingerprint background checks had been completed. Interview on 02/13/19 at 10:40 A.M. with the DOM #500 revealed he had not been required to submit fingerprints prior to starting employment at the facility on 11/26/18. Review personnel file for SW #400 revealed a date of hire of 11/10/18. There was no evidence a BCI & I fingerprint background checks had been completed. Interview on 02/13/19 at 10:40 A.M., SW #400 revealed he had not been fingerprinted since starting employment at the facility on 11/10/18. Review personnel file for DD #143 revealed a date of hire of 10/01/18. There was no evidence a BCI & I fingerprint background checks had been completed. Interview on 02/13/19 at 12:44 P.M., DD #143 revealed she was not required to submit fingerprints since she was hired by the facility	F 0607		

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F 0607	Continued From page 8 10/01/18. Interview on 02/12/19 at 10:23 A.M., Business Office Manager (BOM) #172 verified fingerprint background checks were not completed for STNA #115, STNA #116, STNA #117, STNA #118, RN #310, AA #159, DOM #500, SW #400, and DD #143. BOM #172 revealed the facility had not completed BCI & I fingerprint background checks on employees since 05/2018. BOM #172 verified there are a total of 24 employees who had not completed a BCI fingerprint background check. BOM #172 revealed the facility had been checking employees through an Internet website using their driver license and social security number. The facility identified a total of 24 employees (Dietary Staff #110, LPN #111, STNA #117, MRS #115, Activity Staff #118, LPN #124, LPN #129, STNA #133, LPN #115, Admissions Staff #135, RN #137, STNA #117, DOM #500, SW #400, DD#143, Housekeeper #146, RN #310, AA #159, Receptionist #166, STNA #116, STNA #171, STNA #175, LPN #178 and STNA #118) who had not had their fingerprints submitted to the BCI & I for a background check. Interview on 02/13/19 at 9:59 A.M., AA #159 stated the facility would complete BCI & I fingerprint background checks for employees on 02/14/19. Further interview	F 0607		

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F 0607	Continued From page 9 with AA #159 revealed the facility policy required BCI & I fingerprint checks. Additional interview on 02/13/19 at 12:38 P.M. with AA #159 revealed he was not sure why the facility healthcare company was not requiring BCI & I fingerprint checks. Review the New Hire Checklist form revealed a criminal background check was required. The form indicated the background check should be documented on the Bureau of Criminal Identification (BCI) log. Review of the Personnel File Checklist form revealed BCI & I fingerprint results would be kept in a sealed envelope. Review of the facility policy titled "Abuse: Abuse Prevention Policy & Procedure," dated 01/01/16, revealed the facility would follow state and federal guidelines to prevent abuse, neglect, mistreatment, exploitation, and misappropriation of property. Review of the undated facility policy titled "Ohio Criminal Records Check Notification Policy," revealed pursuant to the Ohio Administrative Code, the facility would initiate a criminal record check and a BCI fingerprint-based check of the employee criminal history.	F 0607		

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F 0623	Continued From page 10	F 0623		
F 0623 SS=D	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)	F 0623	In accordance with regulations Toledo Healthcare will ensure that all hospitalized residents shall receive written notification of transfer to hospital, as well as the resident representative and ombudsman. The Ombudsman was notified of all hospitalizations for the past 30 days as of 3/4/19. The Social Worker was educated on providing written notification to the resident, resident representative, and ombudsman in the event of a facility-initiated discharge/hospitalization by the Administrator on 2/28/19. Administrator will audit Discharge Notice completion every two weeks for 1 month, monthly for 3 months, and quarterly ongoing starting 3/4/19.	03/21/2019

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F 0623	Continued From page 11 (1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection	F 0623		

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F 0623	Continued From page 12 and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This STANDARD is not met as evidenced by:	F 0623		

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F 0623	Continued From page 13 Based on medical record review and staff interview, the facility failed to notify the resident and the resident's representative of a transfer/discharge and failed to send a copy of the notice to the State Long-Term Ombudsman for two (#60 and #72) of two residents reviewed for hospitalization. The facility census was 87. Findings include: 1. Review of the medical record for Resident #60 revealed an admission date of 11/22/18. Diagnoses included encephalopathy, moderate protein-calorie malnutrition, supraventricular tachycardia, muscle weakness, acute kidney failure, hypertension, chronic atrial fibrillation, iron deficiency anemia secondary to blood loss, infection and inflammatory reaction due to indwelling urethral catheter, abdominal aortic aneurysm, without rupture, malignant neoplasm of rectum, and wedge compression fracture of unspecified thoracic vertebra. Further review of the medical record revealed Resident #60 was discharge from the facility on 11/25/18, 12/23/18, 01/15/19, 01/28/19, and 02/06/19. There was no evidence a written notice of transfer/discharge was given to the resident and resident representative on 11/25/18, 12/23/18, 01/15/19, 01/28/19, and 02/06/19. There was also no evidence the Ombudsman was notified of the	F 0623		

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F 0623	Continued From page 14 discharges. 2. Review of the medical record revealed Resident #72 was admitted to the facility on 08/03/18. Diagnoses included chronic obstructive pulmonary disease, dysphasia, anemia, type II diabetes mellitus, hyperlidemia, major depressive disorder, polyneuropathy, hypertension, end stage renal disease requiring hemodialysis, benign prostate hyperplasia , amputation right leg below the knee and severe protein calorie malnutrition. Review of the medical record revealed the resident was hospitalized from 01/19/19 through 01/24/19 for fluid overload. There was no evidence a written notice of transfer/discharge was given to the resident and resident representative on 01/19/19. There was also no evidence the Ombudsman was notified of the discharges. Interview on 02/13/19 at 11:23 A.M., Regional Director of Operations verified the facility has not been giving written notice to the resident or the resident representative upon transfer/discharge from the facility and the Ombudsman has not been notified of the transfer /discharge. Interview on 02/13/19 at 1:22 P.M. with Assistant Administrator verified the facility does not have a policy for transfer/discharge.	F 0623		

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F 0641 SS=D	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This STANDARD is not met as evidenced by: Based on review of medical record review, observation, and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessment for three (#25, #79, and #61) of 19 residents reviewed for MDS assessments. The facility census was 87. Findings include: 1. Review of the medical record revealed Resident #25 was admitted to the facility on 08/08/18. Diagnoses included Huntington's Disease, schizoaffective disorder, anemia, antisocial personality disorder, and osteoarthritis . Review of the quarterly MDS assessment, dated 12/10/18, revealed the resident had moderate cognitive impairment. The resident had hallucinations with no other behaviors identified, including no rejection of care. The resident required supervision with set up for dressing. Observation on 02/12/19 at 10:00 A.M. revealed Resident #25 was wearing the same clothes he had worn for the past three days.	F 0641	In accordance with regulations Toledo Healthcare will ensure that all MDS Assessments are coded accurately. Residents # 25, #79 and #61 were assessed on 2/27/19 by the Director of Nursing/designee for adverse outcomes related to deficient practice and none were observed. The MDS assessment for resident #25, #79, and #61 was modified on 3/5/19 to accurately reflect the corresponding resident. An audit was completed by MDS Coordinator and Regional MDS Nurse of all residents with assistive devices to ensure the accuracy of assessments on 3/5/19. The MDS coordinator and Regional MDS Nurse were educated on accurately coding MDS assessments as outlined in the RAI Manual on 2/26/2019 by the Administrator. The Regional MDS Nurse will audit MDS assessments weekly for 4 weeks, then monthly ongoing. Negative outcomes will be reviewed in QA.	03/21/2019

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F 0641	Continued From page 16 Interview on 02/12/19 at 10:00 A.M., State Tested Nursing Assistant (STNA) #158 stated the resident refused to change his clothes. STNA #158 does not have a lot of clothes and thinks the laundry takes to long to return his clothes. Interview on 02/12/19 at 10:45 A.M., Laundry Assistant #119 she stated the laundry turn around time was one day. Interview on 02/12/19 at 10:00 A.M., Licensed Practical Nurse (LPN) #115 verified she was completing the MDS assessments. She verified Resident #25 was assessed as not rejecting care on the quarterly MDS assessment dated 12/10/18 in section E0800. She verified the resident not changing his clothes daily was considered rejection of care and the MDS assessment was coded incorrectly. 2. Review of the medical record revealed Resident #79 was admitted to the facility on 01/08/13. Diagnoses included anoxic brain damage, anxiety disorder, hypothyroidism, major depressive disorder, vascular dementia, bipolar disorder, psychosis, hypertension, suicidal ideation, and seizure disorder. Review of annual MDS assessment, dated 01/14/19, Section A1500 documented the resident was not considered as a Preadmission Screening and Resident	F 0641		

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F 0641	Continued From page 17 Review (PASRR) Level II due to having serious mental illness or intellectual disability. Review of the PASRR Level II screen completed on 07/14/16 indicated Resident #79 was assessed as a Level II PASRR due to mental illness. The PASRR contained recommendation for medication monitoring and mental health services . Review of the medical record revealed Resident #79 was receiving medication and counseling within the facility. Interview on 02/13/19 at 11:00 A.M., LPN #115 verified Resident #79 had a PASRR Level II assessment with recommendations on 07/14/16. LPN #115 verified Section A1500 was marked incorrectly on the annual MDS assessment dated 01/14/19. 3. Review of the medical record revealed Resident #61 was admitted to the facility on 08/12/14. Diagnoses included schizoaffective disorder, paranoid schizophrenia, weakness, repeated falls, symbolic dysfunction, psychotic disorder with hallucinations, bipolar disorder, Alzheimer's disease, chronic obstructive pulmonary disease, hypertension, major depressive disorder, coronary artery disease, and epilepsy. Review of the MDS assessment, dated 01/09/19, identified the resident with mild cognitive impairment, ability to make	F 0641		

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F 0641	Continued From page 18 needs known, fluctuating attention, and disorganized thinking. The resident's hearing was listed as adequate without the use of a hearing aid. Review of social service progress notes dated 01/30/19 at 9:46 A.M. documented Licensed Social Worker (LSW) #400 sent the resident's hearing aide out for repair. Observation on 02/10/19 at 10:52 A.M. noted Resident #61 in her room watching television. Resident #61 stated she uses bilateral hearing aids and the left hearing aid was sent out for repairs. The resident indicated she was unaware how long the hearing aid has been getting repaired. Review of the Care Card listed Resident #61 had adequate hearing with no use of hearing aids. Interview on 02/12/19 at 10:16 A.M., LPN #202 verified Resident #61 uses bilateral hearing aids. Interview on 02/12/19 11:04 A.M., the Director of Nursing (DON), Assistant DON, and LSW #400 verified Resident #61 uses bilateral hearing aids. The left hearing aid had been sent out for repairs. They verified the resident's hearing impairment and use of aides was not coded correctly on the MDS assessment.	F 0641		

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F 0656	Continued From page 19	F 0656		
F 0656 SS=D	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and	F 0656	In accordance with regulations Toledo Healthcare will ensure that care plans accurately reflect the resident's needs. Resident # 61 was assessed on 2/27/19 by the Director of Nursing/designee for adverse outcomes and none were observed. Like residents were assessed for adverse outcomes related to the deficient practice and none were observed. Resident #61's plan of care was updated to include hearing impairment and use of hearing aids on 2/12/19. Director of Nursing and/or Assistant Director of Nursing will complete an audit of all residents with hearing aids and their corresponding care plans to ensure accuracy by 3/21/19. The Administrator educated the Director of Nursing, Assistant Director of Nursing, and the MDS Coordinator on maintaining accurate care plans on 3/6/19. The Director of Nursing will monitor care plans weekly for 4 weeks, monthly for 2 months, then quarterly ongoing starting on 3/4/19.	03/21/2019

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F 0656	Continued From page 20 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based medical record review, observation and staff interview, the facility failed to develop a plan of care for a hearing deficit for one (#61) of 19 residents reviewed for care plans. The facility census was 87. Findings include: Review of the medical record revealed Resident #61 was admitted to the facility on 08/12/14. Diagnoses included schizoaffective disorder, paranoid schizophrenia, weakness, repeated falls, symbolic dysfunction, psychotic disorder with hallucinations, bipolar disorder, Alzheimer's disease, chronic obstructive pulmonary disease, hypertension, major depressive disorder, coronary artery disease, and epilepsy. Review of the MDS assessment, dated 01/09/19, identified the resident with mild	F 0656		

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F 0656	Continued From page 21 cognitive impairment, ability to make needs known, fluctuating attention, and disorganized thinking. The resident's hearing was listed as adequate without the use of a hearing aid. Review of social service progress notes dated 01/30/19 at 9:46 A.M. documented Licensed Social Worker (LSW) #400 sent the resident's hearing aide out for repair. Review of the current plan of care did not address any hearing deficit or use of hearing aides by Resident #61. Observation on 02/10/19 at 10:52 A.M. noted Resident #61 in her room watching television. Resident #61 stated she uses bilateral hearing aids and the left hearing aid was sent out for repairs. The resident indicated she was unaware how long the hearing aid has been getting repaired. Review of the Care Card listed Resident #61 had adequate hearing with no use of hearing aids. Interview on 02/12/19 at 10:16 A.M., LPN #202 verified Resident #61 uses bilateral hearing aids. Interview on 02/12/19 11:04 A.M., the Director of Nursing (DON), Assistant DON, and LSW #400 verified Resident #61 uses bilateral hearing aids. The left hearing aid had been sent out for repairs. They verified	F 0656		

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F 0656	Continued From page 22 the resident's hearing impairment and use of aides was not on the current plan of care.	F 0656		
F 0657 SS=D	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 0657	In accordance with regulations Toledo Healthcare will ensure that care plans accurately reflect the resident's needs. The Interdisciplinary team clarified the residents fall interventions with residents' input. Resident #25's plan of care was updated on 3/6/19 by the Assistant Director of Nursing to accurately reflect the residents needs. Resident care plans were audited by the Director of Nursing and/or the Assistant Director of Nursing for proper listed interventions for assistive devices by 3/21/19. The Administrator educated the Director of Nursing, Assistant Director of Nursing, and the MDS Coordinator on maintaining accurate care plans on 3/6/19. The Director of Nursing will monitor care plans for appropriate fall interventions weekly for 4 weeks, monthly for 2 months, then quarterly ongoing starting on 3/4/19.	03/21/2019

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F 0657	Continued From page 23 comprehensive and quarterly review assessments. This STANDARD is not met as evidenced by: Based on medical record review,observation,and staff interview, the facility failed to revise the plan of care to included recommended interventions for one (#25) resident out of 19 reviewed for care plans. The facility census was 87. Findings include: Review of the medical record revealed Resident #25 was admitted to the facility on 08/08/18. Diagnoses included Huntington's Disease, schizoaffective disorder, anemia, antisocial personality disorder, and osteoarthritis . Review of the quarterly MDS assessment, dated 12/10/18, revealed the resident had moderate cognitive impairment and hallucinations. The resident was independent with bed mobility transfers, walking in his room, and walking in the corridor. The assessment documented the resident used a walker for ambulation. The resident did not experience any falls since the last assessment. Review of Physical Therapy Evaluation and Treatment Plan, dated 12/03/18, documented the clinical impression was the resident's Huntington disease with	F 0657		

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F 0657	Continued From page 24 recently increased gait impairments due to decreased strength and balance. The goal was to increase the resident functional mobility and reduce falls. A treatment goal included the resident will safely ambulate 200 feet using a two wheeled walker with supervision and verbal cues. Review of a nursing note dated 12/31/2018 at 13:32 P.M. noted a new order was received from physical therapy recommending the resident walk with stand by assistance and use a wheeled walker for mobility at this time. Review of the Physical Therapy Discharge note, dated 01/03/19, contained the discharge recommendation for the resident to receive stand by assistance with the use of a two wheeled walker for mobility tasks at this time. Review of the plan of care, updated 01/11/19, revealed the resident was at risk for falls and injuries due to balance disturbance regarding his disease process. The goal was for the resident to be free of falls through the next review. The interventions did not mention the use of a walker with ambulation. Observation on 02/11/19 at 11:30 A.M., Resident #25 was ambulating throughout the unit with a wheeled walker. On 02/11/19 at 2:30 P.M. the resident was ambulating in the dining room area with a	F 0657		

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F 0657	Continued From page 25 wheeled walker. Observation of the resident on 02/12/19 at 9:30 A.M., the resident was ambulating to activities on the first floor using a wheeled walker. Interview on 02/13/19 at 2:15 P.M., Licensed Practical Nurse (LPN) #176 she verified she had updated the plan of care on 01/11/19. She verified Resident #25 was to use a walker when ambulating. She verified the plan of care did not include the use of a walker with stand by assistance as a fall prevention intervention.	F 0657		
F 0677 SS=D	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This STANDARD is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure personal hygiene dependent residents received assistance to promote personal hygiene. This deficient practice affected one (#80) of two residents reviewed for activities of daily living in a facility census of 87. Findings include:	F 0677	In accordance with regulations Toledo Healthcare will ensure that all residents are provided with proper ADL care. Resident #80 was immediately shaved and groomed. The STNA covering the floor at the time of deficiency was immediately educated on 2/11/19 on ADL care by the Director of Nursing. A facility wide audit of the MDS records was done to identify all residents who are dependent of personal grooming on 2/25/19 by the Director of Nursing and Assistant Director of Nursing. Nursing staff was educated by Director of Nursing on proper ADL care on 2/19/19. The Director of Nursing/designee will observe 5 random residents who are dependent of personal grooming every day for 5 days, weekly for 3 months, then monthly as needed. Negative outcomes will be reviewed in QA.	03/21/2019

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F 0677	Continued From page 26 Review of the medical record revealed Resident #80 admitted to the facility on 10/21/04. Diagnoses included bipolar disorder, psychotic disorder with hallucinations, schizophrenia, polyosteoarthritis, major depression, impulse disorder, cerebral palsy, peripheral vascular disease, and aphasia. Review of the Minimum Data Set (MDS) assessment, dated 01/15/19, identified Resident #80 to have moderate cognitive impairment, no rejection of care, delusions, and total dependence on staff for the completion of activities of daily living. Review of the care plan dated 01/26/19 addressed the resident's dependence on completing activities of daily living. Interventions included the use of a mechanical lift for transfers, and resident totally dependent for toileting and bathing. Observations on 02/10/19 at 12:17 P.M., 02/11/19 at 3:30 P.M., and 02/12/19 at 7:10 A.M., 12:54 P.M., and 2:45 P.M. discovered the resident with matted hair, jagged finger nails with black/brown debris on the underside, and long facial hair present on the cheeks and under the nose. Interview on 02/12/19 at 1:35 P.M., State Tested Nurse Aide (STNA) #111 verified Resident #80's lack of grooming. STNA	F 0677		

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F 0677	Continued From page 27 #111 confirmed responsibility for providing care for the resident. STNA #111 was unaware of the long facial hair, nail condition and matted hair. Interview on 02/12/19 1:40 P.M., Licensed Practical Nurse (LPN) #202 verified the resident's lack of grooming. Interview on 02/12/19 2:58 P.M., the Director of Nursing (DON) and the Assistant DON verified Resident #80 lacked appropriate hygiene.	F 0677		

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F 0689	Continued From page 28	F 0689		
F 0689 SS=D	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This STANDARD is not met as evidenced by: Based on medical record review, observation, and staff interview the facility failed to ensure fall interventions were in place resulting in a fall for one (#25) of two resident reviewed for falls. Additionally, the facility failed to resident rooms were free of hazards for one (#18) out of 19 residents observed during he survey. The facility census was 87. Findings include: 1. Review of the medical record revealed Resident #25 was admitted to the facility on 08/08/18. Diagnoses included Huntington's Disease, schizoaffective disorder, anemia, antisocial personality disorder, and osteoarthritis . Review of the quarterly MDS assessment, dated 12/10/18, revealed the resident had moderate cognitive impairment and	F 0689	In accordance with regulations Toledo Healthcare will ensure that all fall prevention measures are taken and will remove any hazards in resident accessible areas. The RN and STNA's working during the noted deficiency have been individually educated on the fall prevention policy by 3/21/19 by the Director of Nursing. Resident #25 was assessed by the DON on 2/10/19 for adverse outcomes and none were observed. The Nurse working the floor re-educated Resident #25 on the use of his walker. Resident #25 was also seen by therapy to address his fall. The Director of Nursing educated nursing staff on the fall prevention policy by 3/21/19. The Director of Nursing will audit observe 5 random residents with fall interventions weekly for 4 weeks, monthly for 2 months, then quarterly ongoing starting on 3/4/19. Negative outcomes will be reviewed in QA. The bed frame in Resident #18's room was immediately removed on 2/13/19 by the Director of Maintenance. An audit was completed on 2/28/19 to identify any bed frames without a mattress by the Administrator and Director of Maintenance. Administrator educated staff and maintenance director on new maintenance work order request by 3/21/19. The Administrator and/or Director of Maintenance will audit resident rooms to ensure all bed frames have a mattress weekly for 4 weeks, monthly for 3 months, and quarterly ongoing.	03/21/2019

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F 0689	Continued From page 29	F 0689		

hallucinations. The resident was independent with bed mobility transfers, walking in his room, and walking in the corridor. The assessment documented the resident used a walker for ambulation. The resident did not experience any falls since the last assessment.

Review of Physical Therapy Evaluation and Treatment Plan, dated 12/03/18, documented the clinical impression was the resident's Huntington disease with recently increased gait impairments due to decreased strength and balance. The goal was to increase the resident functional mobility and reduce falls. A treatment goal included the resident will safely ambulate 200 feet using a two wheeled walker with supervision and verbal cues.

Review of a nursing note dated 12/31/2018 at 13:32 P.M. noted a new order was received from physical therapy recommending the resident walk with stand by assistance and use a wheeled walker for mobility at this time.

Review of the Physical Therapy Discharge note, dated 01/03/19, contained the discharge recommendation for the resident to receive stand by assistance with the use of a two wheeled walker for mobility tasks at this time.

Review of the plan of care, updated 01/11/19, revealed the resident was at risk

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F 0689	Continued From page 30 for falls and injuries due to balance disturbance regarding his disease process. The goal was for the resident to be free of falls through the next review. The interventions did not mention the use of a walker with ambulation. Observation on 02/10/19 at 11:30 A.M. revealed Resident #25 in the dining room walking around the dining room independently, shuffling his feet, without a walker. Interview on 02/10/19 at 11:30 A.M., Registered Nurse (RN) #137 stated Resident #25 has Huntington's Disease causing him to be unsteady, however he refuses to use a walker. Observation of Resident #25 on 02/10/19 at 12:20 P.M. revealed he stood up from a chair in the dining room and began to walk. He lost his balance and fell forward onto his knees, hitting his cheek on the couch. RN #137 immediately came and assisted the resident up on a chair. She assessed him and found no injury. She left him unattended to get his walker. The resident attempted to stand again when State Tested Nursing Assistant (STNA) #158 assisted him to sit back in the chair. RN #137 brought the walker from the resident's room. The resident stood up and used his walker to ambulate to a chair at the dining room table.	F 0689		

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F 0689	Continued From page 31 Observation on 02/10/19 at 12:50 P.M. revealed the resident stood up from the dining room table and using his walker he ambulated back to his room. On 02/10/19 at 3:30 P.M. the resident was observed ambulating with his walker. Observation of resident on 02/11/19 at 11:30 A.M. revealed the resident was ambulating throughout the unit with a wheeled walker. On 02/11/19 at 2:30 P.M. the resident was ambulating in the dining room area with a wheeled walker. Observation of the resident on 02/12/19 at 9:30 A.M. the resident was ambulating to activities on the first floor using a wheeled walker. At no time during the observations did the resident refuse to use his walker. Observation on 02/12/19 at 11:00 A.M. revealed Resident #25 was observed ambulating to the dining room without his walker. STNA #158 asked the resident where his walker was and instructed him to go back to his room and get it. The resident ambulated back to his room at the end of the hallway with a shuffling gait and obtained his walker. 2. Review of the medical record revealed Resident #18 was admitted to the facility on 05/29/18. Diagnoses included Alzheimer's Disease, anemia, depression, and psychotic disorder.	F 0689		

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F 0689	Continued From page 32 Observation on 02/10/19, 02/11/19, and 02/12/19 revealed the resident was lying on a mattress on the floor in his room. On the floor beside the mattress was a bed frame with the metal bed springs exposed. The hard surface of the bed springs had rough edges. Interview on 02/13/19 at 10:00 A.M., Licensed Practical Nurse (LPN) #131 verified the bed frame without a mattress in the room exposed a hard rough surface. She verified Resident #18 gets up on his own very abruptly and there was a high potential he could fall into the bed frame and springs. She stated the resident wants the mattress on the floor not on the bed frame. She stated she thought there had to be a bed in the room for every resident.	F 0689		

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F 0755	Continued From page 33	F 0755		
F 0755 SS=D	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 0755	In accordance with regulations Toledo Healthcare will ensure that all residents receive medication as prescribed by the physician. Resident #288's physician was notified of the missed medication. Resident #288 received the next scheduled dose of medication. Resident #288 was assessed by the Director of Nursing on 2/10/19 for adverse outcomes and none were observed. Director of Nursing educated all nurses of physician notification of medication errors, and of the use of an emergency pharmacy in the event that medications cannot be obtained timely by 3/21/19. The Director of Nursing will audit newly admitted residents for proper medication administration weekly for 4 weeks, monthly for 2 months, then quarterly ongoing starting on 3/4/19.	03/21/2019

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F 0755	Continued From page 34 This STANDARD is not met as evidenced by: Based on medical record review and staff interview, the facility failed to provide medications as ordered by the physician for one (#288) newly admitted resident out of one reviewed for medications administration following admission. The facility census was 87. Findings include; Review of the medical record revealed Resident #288 admitted to the facility on 02/09/19. Diagnoses included endocarditis, history of substance abuse, methicillin resistant staphylococcus aureus septicemia, bipolar disorder, history of septic embolism, hepatitis C, thrombocytopenia, and malnutrition Review of the nursing admission assessment, dated 02/09/19, identified the resident to be alert, oriented, and able to make needs known. Review of the nurses notes documented the resident arrived at the facility on 02/09/19 at 4:54 P.M. Review of the admission medications orders dated 02/09/19 noted the following medications: the antibiotic Vancomycin infusion intravenously (IV) 1750 milligrams (mg) every 12 hours until 03/12/19, the	F 0755		

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F 0755	Continued From page 35 expectorant guafenesin 600 mg extended release one tablet two times daily, the anticonvulsant gabapentin 300 mg one capsule three times daily, the inhaled glucocorticoid Flonase 50 micrograms (mcg) one spray each nare daily, the antianxiety medication Buspar 10 mg twice daily, and the antidepressants trazadone 50 mg daily and Wellbutrin Sustained Release (SR) 150 mg daily. Review of the nurses notes on 02/10/19 at 5:15 A.M. documented the pharmacy was called due to no medications being delivered for the resident. The pharmacy responded by indicating the medications would be delivered in the evening of 02/10/19. On 02/10/19 at 1:56 P.M. nurses notes document the Vancomycin infused at 12:00 P.M. with no sign or symptom of adverse effects for endocarditis. Review of the February 2019 Medication Administration Record (MAR) revealed the IV Vancomycin was not administered until 02/10/19 at 12:00 P.M. The trazadone was not administered on 02/09/19. The guafenesin and Buspar were not administered until 02/10/19 at 8:00 P.M. The Wellbutrin SR and the Flonase Nasal Spray were not administered until 02/11/19. The gabapentin was not administered on 02/10/19 and 02/11/19 for the 1:00 P.M. dose. The medical record contianed no documentation the physician	F 0755		

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F 0755	Continued From page 36 was notified or an emergency pharmacy was contacted to obtain the medications timely. Interview on 02/11/19 at 3:00 P.M., the Director of Nursing (DON) and Assistant DON (ADON) #174 verified Resident #288 did not receive the IV Vancomycin, trazadone, guafenesin, Buspar, Wellbutrin SR, and Flonase Nasal Spray were not administered timely. They also confirmed the facility uses a emergency pharmacy in the event medications cannot be obtained timely and the emergency pharmacy was not contacted to obtain Resident #288's medications.	F 0755		
F 0812 SS=F	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not	F 0812	In accordance with regulations Toledo Healthcare will ensure that all food is properly labeled. All unlabeled food items were immediately labeled by the Dietary Manager on 2/10/19. All dietary staff have been educated on proper food storage and labeling by 3/4/19 by the Dietary Manager. The Dietary manager will audit the kitchen for unlabeled food every day for 5 days, weekly for 4 weeks, monthly for 3 months, and quarterly ongoing. Negative outcomes will be reviewed in QA.	03/21/2019

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F 0812	Continued From page 37 procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This STANDARD is not met as evidenced by: Based on observation, staff interview, and policy review, the facility failed to label food stored in the refrigerator. This had the potential to affect all 87 residents in the facility who eat food from the kitchen. Findings include: Observation on 2/10/19 at 9:35 A.M. revealed five bowls of cobbler, five cups of pears, and two trays of cups filled with orange juice undated. Interview on 2/10/19 at 9:35 A.M. with Dietary Manager #143 verified there were five bowls of cobbler, five cups of pears, and two trays of cups filled with orange juice undated. Review a posting in the kitchen revealed once a product was opened, it must be labeled with an open date. This includes sauces and beverages.	F 0812		

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F 0867	Continued From page 38	F 0867		
F 0867 SS=F	483.75(g)(2)(ii) QAPI/QAA Improvement Activities §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This STANDARD is not met as evidenced by: Based on review of Quality Assurance Meeting attendance sheets and staff interview, the facility failed to ensure the Administrator attended two of the four quarterly meetings for 2018. This had the potential to effect all 87 residents residing in the facility. Findings include: Review of the undated second quarter (April, May, June) 2018 Quality Assurance Meeting attendance sheet revealed the Medical Director and the Director of Nursing were the only two members in attendance. Review of the undated third quarter (July, August, September) 2018 Quality Assurance Meeting attendance sheet revealed the Medical Director and the Director of Nursing were the only two members in attendance.	F 0867	In accordance with regulations Toledo Healthcare will ensure that all required participants will attend the quarterly assurance meetings. The Quality Assurance meeting for 4th quarter 2018 will take place on 3/11/19. The Administrator from the 2nd and 3rd quarter of 2018 no longer works for Toledo Healthcare. All QA meetings will be attended by the Administrator.	03/21/2019

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F 0867	Continued From page 39 Interview with the Director of Nursing on 02/13/19 at 3:45 P.M. verified the acting Administrator was unable to attend the second and third quarter Quality Assurance Meetings. She stated at that time there was a lot of changes happening within the facility. She stated the current Administrator was not employed by the facility at that time.	F 0867		
F 0880 SS=D	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and	F 0880	In accordance with regulations Toledo Healthcare will ensure that all nurses will follow the policy and procedure for PICC line changes. Resident #288 was assessed by the Director of Nursing on 2/10/19 for adverse outcomes and none were observed. Like residents were assessed for adverse outcomes related to the deficient practice and none were observed. The Assistant Director of Nursing was educated by the Director of Nursing on the catheter insertion/dressing change procedure on 3/5/19. All nurses educated on the catheter insertion/dressing change procedure on 2/11/19 by the Director of Nursing. The Director of Nursing will audit IV dressing changes for proper procedures for 5 days, weekly for three months, then monthly as needed. Negative outcomes will be reviewed in QA.	03/21/2019

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F 0880	Continued From page 40 following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's	F 0880		

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F 0880	Continued From page 41 IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This STANDARD is not met as evidenced by: Based on observation, medical record review, staff interview, and facility policy, the facility failed to follow their policy for the care and treatment of a peripherally inserted central catheter (PICC) line for one (#288) out of one resident reviewed and identified by the facility with a PICC line. The facility census was 87 residents. Findings include; Review of the medical record revealed Resident #288 admitted to the facility on 02/09/19. Diagnoses included endocarditis, history of substance abuse, methicillin resistant staphylococcus aureus septicemia, bipolar disorder, history of septic embolism, hepatitis C, thrombocytopenia, and malnutrition. Review of the nursing admission	F 0880		

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F 0880	Continued From page 42 assessment dated 02/09/19 identified the resident to be alert, oriented, and able to make needs known. Review of the nurses notes documented the resident arrived at the facility on 02/09/19 at 4:54 P.M. Review of hospital documentation dated 02/07/19 revealed Resident #288 had a PICC line placed for the administration of intravenous antibiotic medications. Review of the 02/09/19 admission orders included to change the PICC line weekly. Observation on 02/11/19 at 2:35 P.M. identified Resident #288 with a PICC line placed to the upper right arm. The PICC line insertion site was covered with a gauze a pad and with a transparent semi-permeable membrane (TSM) dressing dated 02/07/19. Review of the facility policy titled "Catheter Insertion and Care; Central Line Venous Catheter Dressing Change," dated 01/01/16, revealed after the original insertion of the PICC. The dressing will be changed within 24 hours and replaced with a sterile transparent dressing. Dressings with TSM covering gauze are to be changed every 48 hours. Interview on 02/12/19 at 9:45 A.M., Assistant Director of Nursing (ADON) #174	F 0880		

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F 0880	Continued From page 43 verified the current PICC line dressing was a gauze pad covering the catheter insertion site and was covered with a transparent semi-permeable membrane (TSM) dressing and dated 02/07/19. The ADON confirmed confirmed the dressing had not been changed since originally inserted on 02/07/19. Additionally, observation on 02/12/19 at 10:28 A.M. noted ADON #174 preparing to change Resident #288's PICC line dressing. ADON #174 obtained a central line dressing change kit and proceed to Resident #288's room. ADON #174 placed the kit on the over bed table at the bedside and washed hands. ADON #174 verified the date on the existing dressing of 02/07/19 and proceeded to open the kit without cleansing the surface of the over bed table. ADON #174 obtained the sterile gloves from the kit, applied them and then removed a sterile drape from the kit and placed it to the surface of the over bed table. ADON #174 continued placing the sterile contents onto the sterile drape. ADON #174 removed the existing PICC dressing with the sterile gloves. ADON #174 proceeded to use a alcohol wipe and removed drainage from the insertion site using the same sterile gloves. ADON #174 followed by wiping the perimeter of the insertion site with chlorhexidine solution. Once the PICC site was dry, ADON #174 placed a new TSM dressing over the site using the soiled sterile gloves.	F 0880		

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F 0880	Continued From page 44 Review of the facility policy titled "Catheter Insertion and Care; Central Line Venous Catheter Dressing Change," dated 01/01/16, to clean the over bed stable with soap and water. The removal of old dressings was with non-sterile gloves. Following removal of the old dressing, open the sterile dressing kit and apply sterile gloves. Interview on 02/12/19 at 11:04 A.M., ADON #174 verified the over bed table was not wiped or cleansed prior to the dressing change. ADON #174 confirmed wearing the sterile gloves during the entire procedure and apply new sterile gloves after removing the old dressing.	F 0880		

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F 0925	Continued From page 45	F 0925		
F 0925 SS=D	483.90(i)(4) Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This STANDARD is not met as evidenced by: Based on observation, staff interview, and policy review, the facility failed to provide effective pest control program in the rooms of two (#22 and #45) of 25 residents who resided on the second floor. The facility census was 87. Findings include: Observation of Resident #22's room on 2/11/19 at 3:24 P.M. and 2/12/19 at 12:18 P.M. revealed dead gnats lying on the window ledge. Observation of Resident #45's room on 2/11/19 at 3:15 P.M. and 2/12/19 at 12:16 P.M. revealed dead gnats lying on the window ledge. Interview on 2/12/19 at 12:18 P.M., with Environmental Services #173 verified dead gnats were lying on the window ledge in Resident #22 and Resident #45's room. Review of the policy titled "Pest Control," dated 1/01/16, revealed the purpose of this policy is to ensure that the facility has a pest control eradication policy.	F 0925	In accordance with regulations Toledo Healthcare will ensure that all resident rooms will be pest free. Residents # 22 and #45 were assessed by the Director of Nursing/designee on 2/27/19 for adverse outcomes related to deficient practice and none were observed. All like residents were assessed by the Director of Nursing /designee on 2/27/19 for adverse outcomes related to the deficient practice and none were observed. The dead gnats located in the window sill of Resident #22's room and Resident #45's room were immediately cleaned by housekeeping staff on 2/13/19. An audit of all resident rooms was completed on 2/22/19 by the Administrator and the Director of Maintenance to locate any more pests. Terminix was in the facility on 2/26/19 to perform the first monthly pest control visit. Administrator educated staff and maintenance director on new maintenance work order request by 3/8/19. Director of Maintenance educated housekeeping staff on pest control policy by 3/5/19. Director of Maintenance will audit resident rooms for signs of pests weekly for 4 weeks, monthly for 3 months, and quarterly ongoing. An audit of all resident rooms was completed on 2/22/19 by the Administrator and the Director of Maintenance to locate any more pests. Terminix was in the facility on 2/26/19 to	03/21/2019

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365886	a. building _____ b. wing _____	02/13/2019

name of provider or supplier	street address, city, state, zip code
TOLEDO HEALTHCARE	2051 COLLINGWOOD BLVD TOLEDO OH, 43620

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F 0925	Continued From page 46	F 0925	perform the first monthly pest control visit. Administrator educated staff and maintenance director on new maintenance work order request by 3/8/19. Director of Maintenance educated housekeeping staff on pest control policy by 3/15/19. Director of Maintenance will audit resident rooms for signs of pests weekly for 4 weeks, monthly for 3 months, and quarterly ongoing.	